

No. 41969-6-II

IN THE COURT OF APPEALS
OF THE STATE OF WASHINGTON
DIVISION II

T. ARTHUR GUSCOTT,

Defendant/Counter-Claimant/Appellant,

vs.

ADVANCED HEALTH CARE, INC. a Washington Corporation,

Plaintiff/Counterclaim Defendant/Respondent.

RESPONDENT ADVANCED HEALTH CARE'S OPPOSITION TO
APPELLANT GUSCOTT'S OPENING BRIEF

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TABLE OF CONTENTS

I. INTRODUCTION AND SUMMARY OF ARGUMENT..... 1

II. RESTATEMENT OF ISSUES ON APPEAL..... 2

III. RESTATEMENT OF THE CASE..... 3

 A. Mr. Guscott Slid Out of His Wheelchair
 on Christmas Day..... 3

 B. Mr. Guscott Had a Huge Pre-Existing Abdominal Aortic
 Aneurysm (AAA), Which the ER Doctor
 Closely Checked..... 4

 C. Three Days After the ER Visit, Mr. Guscott’s
 AAA Ruptured 7

 D. AHC Filed a Lawsuit for Breach of Contract and Mr.
 Guscott Counterclaimed for Negligence 9

 E. AHC Moved to Exclude Mr. Guscott’s Medical Experts
 Under the Frye Test..... 10

 1. The Novel Theories of Mr. Guscott’s Medical
 Expert, Richard Gore, M.D..... 12

 2. The Novel Theories of Mr. Guscott’s ER Expert,
 Ross Heller, M.D 17

 3. The Novel Medical Theory of
 John Holmes, M.D. 18

 F. The Court Granted AHC’s Motion *in Limine* to
 Exclude Mr. Guscott’s Medical Expert Opinions..... 19

 G. The Trial Court Denied Mr. Guscott’s Motion for
 Reconsideration of Its Frye Decision 21

IV.	SUMMARY OF LEGAL ARGUMENTS IN OPPOSITION TO OPENING BRIEF	24
V.	LEGAL ARGUMENT	26
	A. The Standard of Appellate Review Is <i>De Novo</i>	26
	B. In Washington, Novel Theories Are Governed by <u>Frye</u> , Not <u>Daubert v. Merrell Dow Pharmaceuticals</u>	26
	1. The Trial Court Correctly Applied the <u>Frye</u> Test to Novel Medical Expert Theories	28
	2. The Trial Court Correctly Determined that Mr. Guscott Failed to Prove that His Medical Experts’ Opinions Are Generally Accepted In the Scientific Community	29
	C. The <u>Anderson v. Akzo Nobel Coatings, Inc.</u> Decision Supports the Trial Court’s Exclusion Of Mr. Guscott’s Expert Opinions	35
	D. <u>Anderson</u> Slightly Relaxed the Court of Appeals Earlier Application of the <u>Frye</u> Test	38
	E. The Standard of Review Is “Abuse of Discretion” of the Trial Court’s Order Denying Reconsideration	41
	F. The Trial Court Properly Exercised its Discretion in Not Accepting Late Materials	41
	G. Mr. Guscott Was Fully “On Notice” that AHC Was Challenging His Experts Under <u>Frye</u>	46
VI.	CONCLUSION	48
VII.	APPENDIX	A-1 / 50

TABLE OF AUTHORITIES

CASES

<i>Anderson v. Akzo Nobel Coatings</i> , 172 Wn.2d 593, 260 P.3d 857 (2011)	25-29, 35-37, 39-41
<i>Daubert v. Merrell Dow Pharm.</i> , 509 U.S. 579, 113 S. Ct. 2786, 125 L. Ed. 2d 469 (1993).....	26
<i>Frye v. United States</i> , 293 F. 1013, 34 A.L.R. 145 (D.C. Cir. 1923)	<i>passim</i>
<i>Go2Net, Inc. v. CI Host, Inc.</i> 115 Wn. App. 73, 60 P.3d 1245 (2003)	41
<i>Grant v. Boccia</i> , 133 Wn. App. 176, 137 P.3d 20 (2006) <i>overruled in part by Anderson v. Akzo Nobel Coatings</i> , 172 Wn.2d 593, 260 P.3d 857 (2011)	40
<i>Reese v. Stroh</i> , 128 Wn.2d 300, 907 P.2d 282 (1995)	28
<i>Ruff v. Dep't of Labor & Indus.</i> , 107 Wn. App. 289, 28 P.3d 1 (2001) <i>overruled in part by Anderson v. Akzo Nobel Coatings</i> , 172 Wn.2d 593, 260 P.3d 857 (2011)	40
<i>State v. Ahlfinger</i> , 50 Wn. App. 466, 749 P.2d 190 (1988) <i>rev. denied</i> 110 Wn.2d 1035 (1989)	35, 38
<i>State v. Cauthron</i> , 120 Wn.2d 879, 846 P.2d 502 (1993)	26, 30-31, 40, 44
<i>State v. Copeland</i> , 130 Wn.2d 244, 922 P.2d 1304 (1996)	24, 27, 40, 43-46
<i>State v. Martin</i> , 101 Wn.2d 713, 684 P.2d 651 (1984).....	30
<i>State v. Riker</i> , 123 Wn.2d 351, 869 P.2d 43 (1994).....	30

<i>Wilcox v. Lexington Eye Inst.</i> , 130 Wn. App. 234, 122 P.3d 729 (2005) <i>rev. denied</i> 157 Wn.2d 1022, 142 P.3d 609 (2005)	41
--	----

STATUTES

RCW 5.60.050(2).....	3
----------------------	---

RULES

CR 59	3, 25, 41, 43
CR 59(a)(4)	25, 41-43, 45-46
ER 102	28
ER 104(a)	28
ER 401	28
ER 402	28
ER 403	28
ER 702	16, 18-20, 48

OTHER AUTHORITY

5B KARL B. TEGLAND, WASHINGTON PRACTICE: EVIDENCE LAW & PRACTICE § 702.18, at 81 (5 th ed. 2007)	28
<i>State v. Bible</i> , 175 Ariz. 549, 858 P.2d 1152 (1993)	44

I. INTRODUCTION AND SUMMARY OF ARGUMENT

The key issue in this appeal is whether the trial court properly applied the facts to the law in excluding Appellant Guscott's experts' novel medical opinions, based on Frye v. United States.

In 2006, on Christmas day, an 86-year-old gentleman with Parkinson's disease slid out of his wheelchair while an Advanced Health Care employee was pushing his wheelchair on the sidewalk. Mr. Guscott fell onto his buttocks and was in pain. At the time of his fall, Mr. Guscott had a dangerously huge pre-existing abdominal aortic aneurysm ("AAA"). When he went to the emergency room, the doctor, after a thorough examination and various tests, confirmed that it had not ruptured. Mr. Guscott went home with bruises on his buttock and a scraped elbow.

Three days later, Mr. Guscott was experiencing pain and again was taken to the emergency room. A CT scan revealed that the massive AAA had ruptured. Withdrawing a previous 'DNR' directive, Mr. Guscott elected to have it repaired with surgery. The surgery was successful.

Mr. Guscott later sued Advanced Health Care for negligence, arguing that his fall from the wheelchair on Christmas day caused his AAA to rupture. His experts premised their separate causation theories on novel

“junk” science. Consequently, Advanced Health Care challenged the scientific validity of Mr. Guscott’s experts’ opinions and filed a Motion to Exclude the Experts based on the test set forth in Frye v. United States.

Significantly, Mr. Guscott did not submit one *iota* of scientific evidence to the trial court to support the validity of his experts’ novel theories or demonstrate that those theories are generally accepted in the scientific community. Accordingly, the trial court applied the facts to the law and ruled that most of Mr. Guscott’s experts’ opinions were excluded. Mr. Guscott moved for reconsideration, and for the first time submitted a handful of old medical articles—that were available to him before the intense six-week briefing period addressing the exclusion of his experts. In its discretion, the trial court declined to review the new materials, and denied Mr. Guscott’s motion. Mr. Guscott appealed.

Advanced Health Care respectfully requests that the Court affirm the trial court’s rulings.

II. RESTATEMENT OF ISSUES ON APPEAL

- A. Whether the trial court’s ruling should be affirmed when it properly applied the facts to the law under Frye v. United States to exclude novel medical expert testimony because Appellant Guscott failed to

establish that the principles and techniques found general acceptance in the scientific community?

- B. Whether the trial court properly exercised its discretion in denying Appellant Guscott's motion for reconsideration to exclude novel medical expert testimony under Frye, when he failed to meet any of the criteria of CR 59?

III. RESTATEMENT OF THE CASE

A. Mr. Guscott Slid Out of His Wheelchair on Christmas Day.

On Christmas day in 2006, 86-year-old Appellant Arthur Guscott was attending a church service in Olympia with his caregiver, an employee of Respondent Advanced Health Care, Inc. ("AHC") (CP 260-61) Mr. Guscott, who has Parkinson's disease and has used a wheelchair for many years, left the church with his AHC caregiver pushing it. (CP 261) As they headed to the car, his wheelchair went over a small bump in the sidewalk. (CP 261) Mr. Guscott slid out of his wheelchair and onto the ground, landing on his right elbow and buttocks. (CP 257)¹

¹ There is very limited admissible evidence in the record regarding how Mr. Guscott fell because his deposition testimony was ruled incompetent under RCW 5.60.050(2). After a thorough analysis on the issue of Mr. Guscott's competency, the trial court ruled that "I find Mr. Guscott incompetent in light of the medical expert opinion and his apparent inability to relate events truthfully." (CP 341)

The caregiver consulted with AHC's on-call RN supervisor, who recommended that she take Mr. Guscott to the emergency room. (CP 261) ER Dr. Eric Penner ordered a pelvic x-ray to rule out a fracture, and also ordered a blood test, urinalysis, a full EKG, and requested Mr. Guscott's old records. (CP 113-14) All test results were unremarkable. (CP 113) Upon discharge, Mr. Guscott was diagnosed with bruises on his buttocks and a cut on his elbow. (CP 116 at 51:22-25; CP 117 at 52:1-2)

B. Mr. Guscott Had a Huge Pre-Existing Abdominal Aortic Aneurysm (AAA), Which the ER Doctor Closely Checked.

The aorta is typically below the diaphragm and near the spine, and is the biggest blood vessel in the body. (CP 112 at 34:8-9; CP 697 at 7:21-22; CP 698 at 8:6-8) Many years earlier, Mr. Guscott was diagnosed with an abdominal aortic aneurysm ("AAA"), but he did not want it repaired. (CP 108 at 18-19) Dr. Nam T. Tran, Mr. Guscott's treating vascular surgeon, explained that an AAA is "an enlargement of the abdominal aorta that is typically defined as anything larger" than two or three centimeters in diameter. (CP 697 at 7:6-12) Mr. Guscott's AAA was very large at 9.4 centimeters in diameter. In fact, over a six-month period (from June to December 2006) it had grown at a massive rate of 12 additional millimeters in size. (CP 699 at 12:1-3) According to Dr. Tran, the faster the rate of

growth, the higher the risk of rupture. (CP 698 at 11:19-20).

There was a very high risk of a spontaneous rupture due to the massive size of Mr. Guscott's AAA (at 9.4 centimeters in diameter) and the high rate of the recent AAA growth. Dr. Holmes (Mr. Guscott's expert cardiologist) agreed that these two factors significantly increase the risk of an AAA rupture. (CP 677 at 18:2-7; 18:20-23) "There is evidence that as the aneurysm expands, the rate of rupture risk or the risk rate increases." (CP 677 at 18:5-7) Dr. Holmes pegged Mr. Guscott's risk rate for a spontaneous rupture as "high"—approaching 50% chance of a rupture in one year. (CP 678 at 20:3-7)

When Dr. Penner examined Mr. Guscott on December 25, 2006, he was aware of Mr. Guscott's pre-existing condition and thoroughly examined Mr. Guscott to ensure that the AAA had not ruptured. (CP 111-12) Dr. Penner's chart note states that "I considered a worsening abdominal aortic aneurysm. I reviewed his records. He does have a greater than 8 cm aneurysm. If it is ruptured, he does not want surgery as this would be life-threatening. He understands this and chooses not to have surgery." (CP 436) Dr. Penner also knew that Mr. Guscott had signed a "Do Not Resuscitate" instruction. (CP 295)

Specifically, Dr. Penner observed that Mr. Guscott was not guarding his abdomen whatsoever, nor was his abdomen painful. (CP 111) He testified that “When I did an exam on his abdomen, nothing there suggested [a] ruptured AAA.” (CP 111 at 31:19-21) If he diagnoses an AAA rupture, Dr. Penner testified that his “role as the emergency physician is to get [the patient] to a vascular surgeon and try to stabilize [the patient] until the vascular surgeon can attempt to repair his AAA.” (CP 112 at 35:7-10)

He also checked Mr. Guscott’s pulse—which was normal. (CP 112 at 32:3-7) According to Dr. Penner, normality is significant because if “someone has a problem with the big blood vessel that leaves your heart, your aorta, and that supplies your lower extremities, if you have abnormal pulses, that could suggest a problem with the aorta.” (CP 112 at 32:13-16)

When Mr. Guscott initially arrived at the hospital, his first blood pressure reading was 60/9 – which the doctors later agreed was an obvious reading error. Dr. Penner testified that a 60/9 reading is physiologically impossible for a live person. (CP 110 at 26:11-19) His blood pressure steadily rose during his hospital visit. According to Dr. Penner, “The fact that his blood pressure came up and stayed up during that period of observation, exclusive of that initial [60/9 error] blood pressure, which I

don't have a good explanation for, is reassuring.” (CP 115 at 45:23-25; 46:1) Stated differently, Dr. Penner was much less concerned about a leaking AAA because Mr. Guscott's blood pressure was coming up, rather than staying persistently low. (CP 115 at 45:17-19) After determining that Mr. Guscott's AAA had not ruptured, Dr. Penner discharged him and he returned home.

The next day, on December 26, 2006 a nurse from AHC, who made scheduled monthly visits to Mr. Guscott, stopped by to examine his elbow, change the bandage, and tend to his complaints of pain and soreness. (CP 257) The nurse scheduled a follow-up visit with Mr. Guscott's primary physician, Dr. Widrow, for December 28, 2006. (CP 258)

In the early afternoon of December 27, 2006, Mr. Guscott's daughter arrived in town from Chicago for a pre-planned visit. (CP 961) She spent the afternoon and evening with her father, going over his books and finances. (CP 961)

C. Three Days After the ER Visit, Mr. Guscott's AAA Ruptured.

In the middle of the night, around 2 or 3 a.m. on December 28, 2006, Mr. Guscott began moaning in pain, awakening his daughter. (CP 961) She surmised that he might be having a heart attack, despite his indication that he was *not* having chest pain. (CP 961) She gave her father a nitroglycerin pill

and then called 911. (CP 961) An ambulance took Mr. Guscott to St. Peter's Hospital in Olympia. (CP 961)

Sometime around 11:30 a.m. on December 28, 2006, Mr. Guscott had a CT scan, which showed that his pre-existing AAA had ruptured. (CP 961) After consulting with his daughters, Mr. Guscott reversed his earlier DNR instruction, and elected to undergo an AAA repair. (CP 961) The AAA measured 9.4 cm in diameter (CP 96 at 10:11-13), which was huge.

Mr. Guscott's three medical experts unanimously agree that his 9.4 centimeter AAA ran a significant risk of spontaneous rupture.

(1) Dr. Holmes (a cardiologist) testified that a 9.4 centimeter-sized AAA, as well as the high rate of growth created a fairly significant risk of spontaneous rupture. (CP 683 at 40:16-21)

(2) Dr. Heller (an ER physician) testified that risk of a spontaneous rupture for a 9.4 centimeter untreated AAA ranges from 30% to 60% over the course of one year. (CP 745 at 23-26; CP 746 at 69:1-11)

(3) Dr. Gore (a radiologist), agreed with Drs. Holmes and Heller, and confirmed that the size of Mr. Guscott's aneurysm is a significant risk factor for his AAA actually rupturing on its own. "As the aneurysm gets larger the risk of rupture increases." (CP 698 at 9:22-25) Dr. Gore acknowledged that

“AAAs are often referred to as the silent killer, because they normally don’t give any symptoms until all of a sudden there’s a problem.” (CP 714 at 41:20-25)

In fact, Dr. Gore admitted that, under Mr. Guscott’s circumstances, a 9.4 centimeter aneurysm, due to its size, “tends to need to be repaired”—“the reason is because this is a pending rupture.” (CP 715 at 46-47)

Mr. Guscott was flown to Harborview Medical Center in Seattle, where he was examined by the on-call vascular surgeon, Dr. Nam Tran. (CP 691) Following his examination, Dr. Tran performed a “routine” AAA open repair. (CP 691) The surgery was successful. Mr. Guscott was transported by air ambulance to a nursing facility in Illinois, where he currently resides.

D. AHC Filed a Lawsuit for Breach of Contract and Mr. Guscott Counterclaimed for Negligence.

In March 2007, AHC filed a breach of contract claim against Mr. Guscott. (CP 8-11) Mr. Guscott counterclaimed that AHC was negligent for causing him to fall out of his wheelchair and onto the ground, causing him “severe bodily injuries and damages” and that such neglect was also a violation of the Vulnerable Adult Statute. (CP 44-47)

The trial court bifurcated the parties’ claims. (CP 423-24) AHC’s breach of contract claim against Mr. Guscott was settled in November 2009;

Mr. Guscott's negligence claims against AHC were set for trial in Thurston County on January 3, 2011.

E. AHC Moved to Exclude Mr. Guscott's Medical Experts Under the Frye Test.

The key question addressed by medical experts for both parties in this case is whether falling out of a wheelchair and landing on one's buttocks can cause an AAA to leak or rupture three days later. (CP 342) Mr. Guscott's three medical experts (Drs. Gore, Heller and Holmes) used three completely different analyses and theorized in the affirmative.

AHC's medical experts, *including Mr. Guscott's own treating physicians*, disagreed. For example, Dr. Tran—Mr. Guscott's treating vascular surgeon who repaired his ruptured AAA—stated that a fall to a person's buttocks was unlikely to cause an AAA to leak or rupture. (CP 152) Dr. Penner (Mr. Guscott's ER doctor), who treated Mr. Guscott after he slid out of wheelchair on Christmas day in 2006, found no evidence of an AAA rupture, after a thorough examination. (CP 111-12)

On November 18, 2010—six weeks before trial on January 3, 2011—AHC moved to exclude Mr. Guscott's medical experts' testimony because their respective opinions were “novel” and did not meet the “general acceptance” test set forth in Frye. (CP 960-78)

AHC's motion, explicitly titled "Motion *in Limine* Re: Exclusion of Counter-Claimant's Experts," expressly cites, discusses, and applies the "Frye" case at least 11 times with respect to excluding Mr. Guscott's experts. (CP 960-78) AHC clearly stated the relief it sought: "The causation opinions of these three experts should be excluded." (CP 977) In its reply brief, AHC acknowledged "It is true that AHC is asking the Court to strike all of Guscott's [expert] witnesses." (CP 284) Likewise, AHC argued that "Guscott's experts should not be permitted to offer their varying unsupported causation opinions." (CP 285)

Mr. Guscott responded that his experts' opinions "are founded on matters universally accepted in the medical community," (CP 979) but failed to buttress his response with any sort of scientific evidence that the theories and techniques or methods utilized by his experts were generally accepted by the relevant scientific community.

Additionally, Mr. Guscott filed an unsolicited supplemental brief discussing the Frye test as applied to his experts' opinions. (CP 321-27) AHC filed a supplemental response, concluding "AHC has challenged Guscott to meet the basic Frye elements for admission of expert opinion. And in each circumstance, Guscott has failed to do so. Guscott's experts'

respective testimonies must be disallowed.” (CP 338)

AHC argued that Drs. Gore, Heller and Holmes proffered theories on causation (*i.e.*, Mr. Guscott sliding out of his wheelchair and landing on his buttocks caused his AAA to leak or rupture three days later) were inadmissible because both the underlying scientific principle and the technique employing that principle did not find general acceptance in the scientific community. (CP 960-77)

In sum, the Frye Motion *in Limine* was heavily briefed by both parties; the trial court heard oral argument on December 3, 2010; and Mr. Guscott submitted an unsolicited supplemental opposition brief on December 10, 2010, after oral argument on the motion. (CP 787-88)

After hearing oral argument, *inter alia*, on the applicability of Frye the trial court agreed with AHC and excluded Mr. Guscott’s expert opinions in a detailed Letter Opinion, dated December 17, 2010. (CP 340-43)

1. The Novel Theories of Mr. Guscott’s Medical Expert, Richard Gore, M.D.

Mr. Guscott’s medical expert, Dr. Gore (who is a radiologist), contends that Mr. Guscott’s AAA ruptured at the time he fell out of his wheelchair. Dr. Gore’s opinion is based on the following three different theories:

- **Shading of Blood on the CT Scan:** Dr. Gore opines that he can determine the exact day when an aneurysm began to leak based on merely “eyeballing” a CT scan. (CP 239 at 74:6-15; CP 240 at 78) Dr. Gore is convinced that the blood on Mr. Guscott’s CT scan is exactly three days old—and therefore *Mr. Guscott’s aneurysm began leaking when he fell.* (CP 241) Dr. Gore believes that the blood on the CT scan is not two-days old; it is not four-days old. (CP 239-242) It is exactly three-day-old blood, which he determined by “eyeballing” the scan. (CP 239-242)

Dr. Gore readily admits that there are no peer-reviewed articles, texts, etc. that support his ability to identify the age of blood on a CT scan down to the exact day of leakage. (CP 244) When AHC challenged Mr. Guscott about the novelty of Dr. Gore’s theory, Mr. Guscott did not submit any scientific evidence demonstrating that the science and methods of “eyeballing” a CT scan to determine the exact age of blood was generally accepted by the relevant scientific community. (CP 242; CP 244)

- **Slit-Like IVC:** *Dr. Gore theorizes that Mr. Guscott had a slow AAA leak* because there is no evidence of a slit-like inferior vena cava (IVC). (CP 162-64) Dr. Gore believes that while a fast leak/rupture would produce this phenomenon, a slow-leak does not. (CP 162-64)

Again, Dr. Gore readily admits that that he cannot refer to any peer-reviewed articles, texts, etc. that support his opinion that the absence of a slit-like IVC means that the AAA rupture is not acute. (CP 164)

- **Axial Fall:** Dr. Gore theorizes that slipping from a wheelchair—in which a patient lands on his buttocks—can cause the AAA to rupture. (CP 244) Once again, he readily admits that there are no peer-reviewed articles, journals, studies texts, etc. that support his theory. (CP 164)

Rather, he bases the “axial fall” theory solely on one dissimilar experience in over 30 years of practicing medicine. (CP 165) In that one instance, he believes that the patient fell out of a bed at a nursing home—presumably landing on her side, not her buttocks. (CP 165) In that one instance, this patient was brought to the hospital where she was diagnosed with a subdural hematoma, and while reviewing her CT scan, Dr. Gore noticed that there was a ruptured AAA as well. (CP 165-66) Dr. Gore has no additional information, no history of this patient, the nature of the patient’s fall, or whether this patient may have even suffered the rupture of the AAA before the fall (perhaps causing the fall). He is simply presuming that the rupture occurred during the fall. (CP 165-66)

AHC’s Rebuttal Experts Disagree With Dr. Gore. AHC’s rebuttal

experts include Mr. Guscott's two treating physicians, Dr. Penner (his ER doctor on Christmas day) and Dr. Tran (his vascular surgeon who repaired his AAA). (CP 962) AHC also retained a world-renowned vascular surgeon, Kaj Johansen, M.D. and a radiologist, Michael Peters, M.D. (CP 962)

Dr. Penner testified that he examined Mr. Guscott for a ruptured AAA on Christmas day in the emergency room, and it had not ruptured. (CP 148). Dr. Tran testified that it was highly unlikely that a fall from a wheelchair could have caused the AAA to rupture because you do not sustain any direct trauma to the abdominal area (such as a seatbelt), but rather Mr. Guscott landed on his buttocks. (CP 152)

Dr. Tran also testified that it is difficult to accurately determine when an aneurysm began to leak based on viewing a CT scan. (CP 97 at 13:11-21) Dr. Tran stated that the only way to determine the duration of a leak is to take a history from the patient and determine when objective symptoms began. (CP 97 at 13:15-21)

Dr. Peters (AHC's expert radiologist) testified that determining the exact age of blood is not possible—either by “eyeballing” at CT scan or considering Hounsfield Units. (CP 816)

Dr. Kaj Henry Johansen, a vascular surgeon like Dr. Tran, is a world-

renowned expert on ruptured aneurysms from serving as Chief of the Vascular Surgery Department at Harborview Medical Center for 15 years. (CP 143 at 7:5-8) He has treated ruptured aortic aneurysms since his first day of practice; is well-published in his field; and operated and cared for hundreds and hundreds of patients with ruptured AAAs. (CP 143 at 6-7)

Dr. Johansen unequivocally testified that Mr. Guscott's AAA rupture was not caused by his Christmas day slip from the wheelchair. (CP 143) Dr. Johansen succinctly stated (at CP 144 at 11:7-16):

While Guscott's experts have talked voluminously and repeatedly about how trauma causes aneurysms to rupture, there is neither in the medical literature, nor experience of people who actually take care of them, nor biologically, which is to say, in animal systems, nor in terms of physics of it, is there any sort of sense of trauma of the sort that Guscott suffered caused—would cause an aortic aneurysm, however large, to rupture.²

The Trial Court Order. On December 17, 2010, the Honorable Carol Murphy entered a Letter Opinion ruling that Dr. Gore was qualified as an expert under ER 702, but that the record lacks support for his scientific opinions under Frye. (CP 341) “There is nothing in the record supporting this theory of dating a leak based on a CT scan from a scientific perspective, however, and that is necessary in light of the contradictory evidence from Dr. Tran. This testimony is disallowed under *Frye*.” (CP 343)

² A key excerpt from Dr. Kaj Henry Johansen's deposition testimony is attached hereto as an Appendix.

2. The Novel Theories of Mr. Guscott's ER Expert, Ross Heller, M.D.

Mr. Guscott's next medical expert, Dr. Heller, offers a different theory than Dr. Gore as to the cause of the AAA. He theorizes that the AAA began leaking on Christmas day, but that it immediately clotted (*i.e.*, stopped) before Mr. Guscott even reached the ER to be examined, and then three days later the clot retracted and began to leak again. (CP 175)

Dr. Heller theorizes that (a) Mr. Guscott's fall and "deceleration" injury caused his aorta to tear; (b) immediately after falling, Mr. Guscott began experiencing symptoms consistent with a tear, included pain and a lower blood pressure; and (c) such tears typically present with initial hypotension and pain, and because they are retro-peritoneal in nature, they can clot and then re-bleed. (CP 175)

Notably, Dr. Heller also theorizes that Mr. Guscott's AAA leaked/ruptured at the time of his fall, but that the AAA self-clotted while Mr. Guscott was at the emergency room on December 25, 2006. (CP 175; 251 at 40:2-10) Then, as the clot shrunk, the AAA leak re-bled three days later. (CP 175; CP 251)

AHC moved to exclude Dr. Heller because his medical theories were novel, strange, undocumented, and unsupported by a single peer-reviewed

article. (CP 960-77) Other than his “*say so*,” Dr. Heller proffered no scientific evidence to suggest that an AAA can rupture, then immediately self-clot, then retract and re-bleed days later, and that such an occurrence is generally accepted in the relevant medical community. (CP 142 at 53-54)

On December 17, 2010, the Honorable Carol Murphy entered a Letter Opinion ruling that Dr. Heller was qualified under ER 702, but that there was no scientific basis in the record for his belief that an AAA can begin to leak, then clot to stop the leak. (CP 343)

3. The Novel Medical Theory of John Holmes, M.D.

Dr. Holmes, a cardiologist, theorized that: (a) falls can cause existing AAAs to leak as a result of deceleration and shearing forces involved; and (b) the Christmas day fall is the most likely occurrence only because of its temporal proximity—three days later—to the discovery of a leak. (CP 157)

Significantly, Dr. Holmes presented no peer-reviewed articles, journals, texts, etc. to support his theory. (CP 156) He could not cite to a single article that suggested axial forces, such as those allegedly experienced in Mr. Guscott’s fall, can lead to a ruptured AAA. (CP 156) Further, he has no personal experience with a deceleration-type injury that may cause a rupture of an existing AAA. (CP 156) In fact, he cannot recall ever having

treated a patient who fell out of a wheelchair. (CP 157)

In sum, Dr. Holmes theorizes that Mr. Guscott's rupture was discovered within three days of the fall, therefore it was probably the fall that caused the rupture.

Dr. Holmes' novel theory was heavily criticized by AHC's expert, Dr. Johansen, who has the most extensive experience in the United States in treating and studying ruptured aneurysms. (CP 144 at 5-8) Dr. Johansen testified that only a "penetrating" trauma (not sliding out of a wheelchair) could cause an aneurysm to traumatically rupture. (CP 144 at 11:17-25) Examples of a penetrating trauma include a gunshot wound, stab wound, or severe deceleration where your car hits the bridge at 70 mph and causes your seatbelt to sever the aorta. (CP 144 at 11:17-25)

Finally, Dr. Johansen, pegged the risk of a spontaneous rupture occurring on a 9.4 centimeter AAA within one year "in the neighborhood of 90 percent." (CP 145 at 17:12-25; CP 146 at 18:1)

On December 17, 2010, the Honorable Carol Murphy entered a Letter Opinion ruling that Dr. Holmes was qualified under ER 702, but that the record lacks support for his scientific opinions under Frye. (CP 341)

F. The Court Granted AHC's Motion *in Limine* to Exclude Mr. Guscott's Medical Expert Opinions.

On December 17, 2010, after reviewing and considering 22 documents submitted by both parties and hearing oral argument, the Honorable Carol Murphy entered a Letter Opinion ruling that Mr. Guscott's experts are qualified under ER 702, but that the record lacks support for their scientific opinions under Frye. (CP 341)

Specifically, she ruled as follows:

- Advanced Healthcare has satisfied its prima facie burden to show that Mr. Guscott's experts present novel scientific theories.
- The major issue in this case is whether falling out of a wheelchair and landing on one's buttocks can cause an AAA to leak or rupture.
- Each of Mr. Guscott's three experts hold this opinion, which is contested by Advanced's experts, yet there is no scientific basis in the record to support that the principle is generally accepted in the scientific community.
- It is agreed that a major trauma localized to the aneurism, such as a seat belt's impact during a car accident, can cause an aneurism to leak or rupture. However, [Mr. Guscott's treating] vascular surgeon Dr. Nam Tran stated that a fall to a person's buttocks was unlikely to cause an AAA to leak or rupture.
- Mr. Guscott's three experts conceded that they did not know of any scientific literature supporting their theories. Guscott has not found and provided any such literature, nor has he provided any other scientific evidence to support his theory, despite ample opportunity to do so.
- This testimony is stricken under *Frye*.

(CP 342 (emphasis added))³

The trial court also entered a Summary Judgment Order on January 3, 2011, finding that (1) Guscott conceded in open court that his claimed damages all relate to his ruptured abdominal aortic aneurysm; and *inter alia* (2) based on the court's Frye ruling, Guscott further conceded in open court that he is unable to establish a casual relationship between his wheelchair fall and his claimed injury of a ruptured abdominal aortic aneurysm. (CP 942)

G. The Trial Court Denied Mr. Guscott's Motion for Reconsideration of Its Frye Decision.

Mr. Guscott presented five arguments in support of his Motion for Reconsideration of the order excluding his medical experts' testimony. (CP 373-96) However, Mr. Guscott did not identify—as expressly mandated by CR 59—the specific basis of his motion. (CP 373-96) Also, Mr. Guscott submitted additional material, in derogation of CR 59, which he could have discovered and produced much earlier with his responses and supplemental briefing, with reasonable diligence. (CP 433-64; CP 487-652; CP 756-63)

³ The trial court found three uncontroverted scientific opinions that withstood Frye and were admissible, if relevant. “First, Drs. Holmes and Gore testified why a person such as Mr. Guscott would refuse aneurism surgery when offered before the fall. They both testified why surgery would not be in the patient’s best interest, even though the aneurism was very likely to ultimately kill him.” (CP 434) Second, “all of the experts agree that Mr. Guscott’s aneurism was large.” (CP 343) Third, Dr. Holmes’ testimony regarding typical growth rate for aneurysms and the risk of rupture based on size, citing the Lederle study, was uncontroverted. (CP 343)

The trial court denied reconsideration without oral argument regarding Mr. Guscott's first four arguments. (CP 783-84) The court reiterated that it "found persuasive the fact that no scientific evidence was presented to support the experts' novel theories." (CP 783)

In addressing the first four arguments, the trial court restated its prior rulings: (1) clarifying that the trial court generally found "that there was an insufficient basis under *Frye* to admit expert opinion that the fall that occurred around Christmas caused Mr. Guscott's AAA to leak or rupture." (CP 784) The trial court clarified that it did not need to resolve disputed findings (whether Mr. Guscott fell on his buttocks or fell on his elbow and perhaps his side) in order to make its ruling. (CP 784)

Second, the trial court reiterated its prior ruling that Mr. Guscott did "not necessarily have to present scientific studies, *but he must present some evidence to show acceptance in the scientific community of his expert's theories.*" (CP 784 (emphasis added)) With respect to arguments three and four, the trial court simply ruled that they were repetitious and failed to present a meaningful basis for reconsideration. (CP 784)

With respect to Guscott's fifth argument, he asked the trial court to consider scientific evidence for the first time in his motion for

reconsideration (albeit, in hindsight, and with unpersuasive scientific evidence). Mr. Guscott did not argue that this evidence was previously unavailable, but rather stated that “*he did not believe that the court would rule in the way that it did and therefore did not think he had to present this evidence in earlier proceedings.*” (CP 784 (emphasis added.)) The trial court scheduled oral argument for March 3, 2011, solely on the issue of whether newly submitted evidence warrants reconsideration of the trial court’s Frye ruling. (CP 953-55)

Following oral argument, the trial court denied reconsideration, ruling as follows:

- Guscott was on notice that AHC questioned the experts put forth by Guscott. “The parties knew what was at issue, and the burdens were well known in terms of what needed to be brought forth in light of the challenge.
- At the time of being so challenged, Guscott had a threshold burden to present evidence in light of the challenge to his experts. Guscott was provided a full opportunity at that time and he did not meet that threshold burden.
- The new materials that have been brought forth in Guscott’s Motion for Reconsideration were available to Guscott previously at the time the Court considered the initial Motion *in Limine*.
- It also appears from Guscott’s most recent submissions that since the initial Motion *in Limine*, opinions of Guscott’s experts have changed—both in substance and basis. New theories are not admissible on motions for reconsideration.

Finally, the trial court agreed with AHC's interpretation that State v. Copeland (1) allows an appellate court, not a trial court on reconsideration, to consider new materials outside the record; and (2) acknowledges that "new technology, evolving at a pace where general acceptance changes *from time of trial to time of appellate review* is at [the] core of what *Frye* is designed to scrutinize." State v. Copeland, 130 Wn.2d 244, 257, 922 P.2d 1304 (1996). Accordingly, the appellate court reviews only evidence that was unavailable at the time the trial, such as heretofore unpublished papers, test results, etc. The appellate does not review evidence previously available to a party, but not utilized.(CP 953-55)

On April 1, 2011, Mr. Guscott filed a Notice of Appeal of the Order on Summary Judgment; Orders *in Limine* re Frye; and Order Denying Reconsideration. (CP 938-55) Mr. Guscott's Opening Brief does not assign error to the trial court's Order excluding Mr. Guscott's deposition transcript and the trial court's finding that Mr. Guscott was incompetent to testify. Accordingly, that issue is waived on appeal.

IV. SUMMARY OF LEGAL ARGUMENTS IN OPPOSITION TO OPENING BRIEF

The Court is the gatekeeper of inadmissible evidence based on novel theories that are not generally accepted in the relevant scientific communities.

As a gatekeeper, it is armed with the Rules of Evidence and the additional tool of Frye v. United States, which is currently the legal standard in civil and criminal cases governing admissibility of novel theories and principles.

The recent Supreme Court case, Anderson v. Akzo Nobel Coatings, reiterates the scope and proper application of the Frye test while also relaxing a previously stringent use of Frye in two Court of Appeals decisions. Anderson is also helpful in the case at bar.

The trial court properly excluded the novel theories of Guscott's medical experts by applying the facts to the law set forth in Frye. Mr. Guscott never once submitted an *iota* of scientific evidence in support of his experts' theories during the trial court proceedings. Under a *de novo* review, the trial court's orders should be affirmed.

Inexplicably, Mr. Guscott submitted over 250 pages in support of his Motion for Reconsideration, which included a handful of old scientific articles. However, Mr. Guscott ignored the Civil Rules governing the submission of new evidence (CR 59(a)(4)) and the mandates of CR 59. The trial court correctly ruled that all of those materials were previously available to him during the extensive six-week Motion *in Limine* practice, and denied Mr. Guscott's Motion for Reconsideration in numerous lengthy orders. The

trial court properly exercised its discretion in denying the motion.

AHC respectfully requests that the Court of Appeals affirm the Thurston County Superior Court's Orders Granting AHC's Motion *in Limine* to Exclude Experts, and Denying Mr. Guscott's Motion for Reconsideration.

V. LEGAL ARGUMENT

A. The Standard of Appellate Review Is *De Novo*.

A trial court's decision to admit or exclude novel scientific evidence is reviewed *de novo*. Anderson v. Akzo Nobel Coatings, 172 Wn.2d 593, 602, 260 P.3d 857 (2011); State v. Cauthron, 120 Wn.2d 879, 887, 846 P.2d 502 (1993).

B. In Washington, Novel Theories Are Governed by Frye, Not Daubert v. Merrell Dow Pharmaceuticals.

Inexplicably, Mr. Guscott assigns error to the trial court's application of the Frye test to his medical experts' novel theories and techniques, suggesting that the issue is "ripe for review" for the Court of Appeals to reject Frye and apply the "reliability" standard in Daubert v. Merrell Dow Pharm., 509 U.S. 579, 113 S. Ct. 2786, 125 L. Ed. 2d 469 (1993). (Appellant's Opening Brief at 42) However, Mr. Guscott fails to explain or justify with law or facts why Daubert should apply to his case. His suggestion is also belied by the fact that he heavily relies on the

Supreme Court’s analysis governing the admissibility of medical expert opinion in Anderson v. Akzo Nobel Coating—which is the same case that painstakingly applies the law of Frye, not Daubert to the facts.

First, just a few months ago, our Supreme Court carefully applied Frye, not Daubert to its evidentiary analysis in Anderson v. Akzo Nobel Coatings. Because the parties and trial court applied Frye, the Supreme Court assumed “without deciding that *Frye* is the appropriate test for civil cases.” Anderson, 172 Wn.2d at 603. Appellant Guscott agrees, admitting that the Anderson Court “revisits and reiterates the applicability of *Frye* in a civil case[.]” (Appellant’s Opening Br. at 1)

The Anderson Court had the ripest opportunity to apply Daubert’s “reliability” test instead of Frye’s “general acceptance” test to the admissibility of novel science, but declined. Instead, the Supreme Court took great care to thoughtfully discuss and delineate the nuances and application of Frye to civil cases. See Anderson, 172 Wn.2d at 601-09. Likewise, in criminal cases “we declared our continued adherence to the more stringent *Frye* test.” Id. at 602, citing State v. Copeland, 130 Wn.2d 244. As such, the Court of Appeals, here, should defer to the Supreme Court’s continued application of Frye and likewise decline to employ Daubert’s reliability test.

1. The Trial Court Correctly Applied the Frye Test to Novel Medical Expert Theories.

The trial court's role as a gatekeeper is to determine if the evidence is admissible. ER 102; ER 104(a); Anderson, 172 Wn.2d at 606. "To satisfy the pursuit of truth, evidence must meet certain criteria. Evidence must be probative, relevant, and meet the appropriate standard of probability." Id.; see also ER 102, ER 401, ER 402; ER 403.

The Anderson Court acknowledged that "[e]videntiary rules provide significant protection against unreliable, untested, or junk science." Anderson, 172 Wn.2d at 606, citing 5B KARL B. TEGLAND, WASHINGTON PRACTICE: EVIDENCE LAW & PRACTICE § 702.18, at 81 (5th ed. 2007). Accordingly, the "*Frye* test is an additional tool used by judges when the proffered evidence is based upon novel theories and novel techniques or methods." Anderson, 172 Wn.2d at 606, citing Reese v. Stroh, 128 Wn.2d 300, 306, 907 P.2d 282 (1995).

Here, AHC unquestionably implicated Frye by challenging Mr. Guscott's medical expert opinions as being based on novel or junk science. As the Anderson Court explained, Frye applies "where either the theory or technique or method of arriving at the data relied upon is so novel that it is not generally accepted by the relevant scientific community." Anderson, 172

Wn.2d at 611.

In response to AHC's challenge, Mr. Guscott's burden was to establish that each of the respective novel theories or principles of Drs. Gore, Holmes, and Heller has achieved general acceptance in the relevant scientific community. However, Mr. Guscott completely failed to meet AHC's *Frye* challenge because he did not submit one *iota* of scientific evidence demonstrating general acceptance in the scientific community. The trial court's ruling excluding the medical opinions of Drs. Gore, Holmes, and Heller was correct and should be affirmed.

2. The Trial Court Correctly Determined that Mr. Guscott Failed to Prove that His Medical Experts' Opinions Are Generally Accepted in the Scientific Community.

First, our Supreme Court affirmed that "under *Frye*, the court's role is to determine whether the theory has been generally accepted in the relevant scientific community." Anderson, 172 Wn.2d at 601. To determine if an expert's opinion satisfies the Frye test, the courts consider "(1) whether the underlying theory is generally accepted in the scientific community and (2) whether there are techniques, experiments, or studies utilizing that theory which are capable of producing reliable results and are generally accepted in the scientific community." Id. at 603, *quoting State v. Riker*, 123 Wn.2d

351, 359, 869 P.2d 43 (1994).

The Cauthron Court stated: “The rule is settled: ‘[E]vidence deriving from a scientific theory or principle is admissible only if that theory or principle has achieved *general acceptance* in the relevant scientific community’” State v. Cauthron, 120 Wn.2d 879, 886, 846 P.2d 502 (1993) (quoting State v. Martin, 101 Wn.2d 713, 719, 684 P.2d 651 (1984) (emphasis added)). Accordingly, the classic statement of the test is found within Frye itself:

Just when a scientific principle or discovery crosses the line between the experimental and demonstrable stages is difficult to define. Somewhere in this twilight zone the evidential force of the principle must be recognized, and while courts will go a long way in admitting expert testimony deduced from a well-recognized scientific principle or discovery, the thing from which the deduction is made must be sufficiently established to have gained *general acceptance* in the particular field in which it belongs.

Frye v. United States, 293 F. 1013, 1014, 34 A.L.R. 145 (D.C. Cir. 1923)

(emphasis added).

The Cauthron Court explained that:

[u]nder Frye, a court is to determine if the evidence in question has a valid, scientific basis. Because judges do not have the expertise required to decide whether a challenged scientific theory is correct, we defer this judgment to scientists.”

Cauthron, 120 Wn.2d at 887.

Thus, the “inquiry turns on the level of recognition accorded to the scientific principle involved -- we look for general acceptance in the appropriate scientific community.” Id. If there is a significant dispute between qualified experts as to the validity of scientific evidence, it may not be admitted. Id.

AHC’s experts all established that Mr. Guscott’s experts’ theories lacked scientific support. In response, Mr. Guscott merely had to provide evidence from the scientific community that his experts’ theories were generally accepted. He did not submit a shred of evidence. In general all three experts used completely different theories to reach the baseless conclusion that a slip from a wheelchair can lead to an AAA rupture.

The theories that AHC challenged are summarized as follows:

- **Dr. Gore:** Are the science and methods widely accepted in the relevant scientific community to support his theory that he can “eyeball” a CT scan and determine—from the shading—that the blood is three days old, rather than two days or four days old? Is there any scientific evidence to support his “IVC” theory?
- **Dr. Heller:** Are the science and methods widely accepted in the relevant scientific community to support his theory that a slip from a

wheelchair seat to the ground can cause a very large AAA to rupture—but then quickly clot before the patient reaches the ER, and then three days later re-bleed?

- **Dr. Holmes**: Are the science and methods widely accepted in the relevant scientific community to support his *res ipsa loquitur* theory that Mr. Guscott's rupture was discovered within three days of the fall, therefore it was probably the fall that caused the rupture?

AHC challenged these theories, utilizing Mr. Guscott's own treating physicians. Dr. Penner (his ER doctor) testified that he examined Mr. Guscott for a ruptured AAA on Christmas day in the emergency room, and it had not ruptured. (CP 148)

Dr. Tran (his vascular surgeon) testified that it was highly unlikely that a fall from a wheelchair could have caused the AAA to rupture. (CP 152) Dr. Johansen, a vascular surgeon like Dr. Tran, unequivocally testified that Mr. Guscott's AAA rupture was not caused by his Christmas day slip from a wheelchair. (CP 143 at 13:11-21) Dr. Tran also testified that it is difficult to accurately determine when an aneurysm began to leak based on viewing a CT scan. (CP 97 at 13:11-21) Dr. Tran stated that the only way to determine the duration of a leak is to take a history from the patient and determine when

objective symptoms began. (CP 97 at 13:15-21) Here, the acute symptoms reflected in the record are consistent with an AAA rupture occurring three days, post accident.

Mr. Guscott responded to the Frye challenge with intense briefing and an *ad nauseam* reiteration of his experts' opinions, but absolutely failed to submit any scientific evidence demonstrating that the novel theories or principles have achieved *general acceptance* in the relevant scientific community. Given this dearth of evidence, the trial court properly excluded the opinions of Drs. Gore, Heller, and Holmes.

Mr. Guscott baldly contends that "The record establishes Mr. Guscott's experts relied on their training, practical experience and acquired knowledge, rendering *Frye* inapplicable." (Appellant's Opening Brief at 22) However, with respect to personal experience, Mr. Guscott's expert, Dr. Holmes, testified as follows:

Q: Do you have any personal experience with a deceleration type injury specifically causing a rupture of an existing AAA?

A: Of a AAA, no.

Q: Have you provided me then with the sum total basis for your opinion that falls can cause existing AAA's to leak as a result of deceleration and shearing forces?

A: It's my opinion that that's the case.

Q: No, I understand that. But have you in the last few minutes ---

A: There is no study of AAA patients and deceleration injuries that I am aware of.

(CP 157) Upon further questioning, Dr. Holmes was asked:

Q: Have you ever treated a patient who fell out from a wheelchair?

A: I probably have, but I can't recall.

(CP 157) Mr. Guscott's experts not only fail to produce scientific evidence to support their novel theories, but also have absolutely *no experience* of utilizing the very theories they espouse.

Dr. Gore claims to base his opinions on his experience, however, he is only aware of one (1) case in over 30 years of practicing medicine in which he believes that a fall lead to a traumatic rupture of an AAA. In that case, he claims the patient fell out of bed at a nursing home—presumably landing on her side, not her buttocks. The patient was brought to the hospital where she was diagnosed with a subdural hematoma; and while reviewing the CT scan, Dr. Gore noticed a ruptured AAA as well. (CP 165-66) Dr. Gore has not other information or experience than this. He knows nothing about the patient's history; the nature of the patient's fall; or whether the patient may have even suffered an AAA rupture before the fall. He is only *presuming* that

the rupture occurred during the fall.

Finally, Dr. Heller has absolutely no scientific community-vetted basis for his “bleed, then heal/reclot, then re-bleed over a 3-day period.” He claims that his opinions are based on his experience, but has no definitive basis for supporting his opinions through experience.

Whether a scientific method or technique is generally accepted requires more than the bare assertion by an expert witness that the technique is reliable. State v. Ahlfinger, 50 Wn. App. 466, 469, 749 P.2d 190 (1988), *rev. denied* 110 Wn.2d 1035 (1989).

C. . The Anderson v. Akzo Nobel Coatings, Inc. Decision Supports the Trial Court’s Exclusion of Mr. Guscott’s Expert Opinions.

Appellant Guscott emphatically waves around the latest Supreme Court ruling as if the gates of admissibility have been flung wide open for any and all expert testimony—including his experts, regardless of how absurd or illogical. However, the Court’s opinion in Anderson v. Akzo Nobel Coatings, Inc., 172 Wn.2d 593, 260 P.3d 857 (2011) supports the trial court’s Frye analysis and exclusion of Mr. Guscott’s expert medical opinions.

In Anderson, plaintiff Julie Anderson mixed paint for her employer, Akzo Nobel Coatings, Inc., sometimes on a daily basis. She gave birth to a son, Dalton, in 2000. Id. at 597-98. By 2003, it was clear that Dalton had

medical abnormalities, including delays in motor, communication, cognitive and adaptive behavior. Id. at 598. In searching for a cause, Dalton’s treating physician, Dr. Chris Stefenelli, concluded that “Dalton’s developmental malformations were likely due to his mother’s paint exposure at Akzo.” Id.

Anderson sued Akzo for negligence, claiming that her child’s medical abnormalities were caused by in utero exposure to toxic materials at Akzo. Id. at 595-96. She hired a medical expert, Dr. Sohail Khattak, who “was willing to testify that Dalton’s birth defects were caused by organic solvent exposure.” Id. at 598.

Unlike Mr. Guscott’s medical experts in the case at bar, Dr. Khattak had (a) relied upon the opinions of Dalton’s treating physicians, as well as Akzo’s material safety data sheets; and (b) published a paper in the Journal of the American Medical Association on the correlation between exposure to organic solvents in utero and birth defects, while a fellow at a division of Clinical Pharmacology and Toxicology at the University of Toronto. Id. at 608. This published paper directly addressed the exact issue in the litigation: whether a woman’s exposure to organic solvents, while she is pregnant, can cause birth defects. Id. at 604-05.

Notably, the Supreme Court found persuasive that Dr. Khattak relied

on Dalton's treating cardiologist, who opined that "Dalton's significant medical problems may *very likely* be as a result of significant exposure to organic solvents in utero." *Id.* at 604. In contrast, Mr. Guscott's medical expert, Dr. Gore, eschewed the opinion of Mr. Guscott's own treating vascular surgeon. Dr. Tran, who performed the AAA repair opined that it was *highly unlikely* that a fall from a wheelchair could have caused the AAA to rupture. (CP 152)

Unlike Mr. Guscott, plaintiff Julie Anderson submitted medical expert opinion that was substantiated by scientific evidence. Akzo challenged the sufficiency of the evidence with respect to its exactitude. The Supreme Court stated that to "require the exacting level of scientific certainty to support opinions on causation would, in effect, change the standard for opinion testimony in civil cases." *Id.* at 608. *In contrast to Julie Anderson, Mr. Guscott did not submit anything—no scientific evidence whatsoever to support any novel theory proffered by his three experts.*

Mr. Guscott presented absolutely nothing to the trial court to satisfy the Frye test, when AHC challenged the following novel theories:

- **Dr. Gore:** Are the science and methods widely accepted in the relevant scientific community to support his theory that he can

“eyeball” a CT scan and determine—from the shading—that the blood is three days old, rather than two days or four days old? Is there any scientific evidence to support his “IVC” theory?

- **Dr. Heller**: Are the science and methods widely accepted in the relevant scientific community to support his theory that a slip from a wheelchair seat to the ground can cause a very large AAA to rupture—but then quickly clot, and then three days later re-bleed?
- **Dr. Holmes**: Are the science and methods widely accepted in the relevant scientific community to support his *res ipsa loquitur* theory that Mr. Guscott’s rupture was discovered within three days of the fall, therefore it was probably the fall that caused the rupture?

Whether a scientific method or technique is generally accepted requires more than the bare assertion by an expert witness that the technique is reliable. State v. Ahlfinger, 50 Wn. App. 466, 469, 749 P.2d 190 (1988). With respect to Mr. Guscott’s experts, that’s all we have. Accordingly, the trial court’s order should be affirmed.

D. Anderson Slightly Relaxed the Court of Appeals Earlier Application of the Frye Test.

The Anderson Court applied the Frye test to determine that the

plaintiff's expert's testimony (in that case, Dr. Khattak) was admissible because his opinion was based on science and methods widely accepted in the relevant scientific community. "[T]he plaintiff presented evidence that tended to show it is generally accepted by the scientific community that toxic solvents like the ones to which Anderson was exposed are fat soluble, pass easily through the placenta and dissolve into the amniotic fluid inside the uterus, and may damage the developing brain of a fetus within the uterus." Id. at 610.

The Supreme Court rejected Defendant Akzo's argument that the causal relation between exposure to organic solvents and birth defects must be exacting. Akzo argued that to satisfy Frye, "Anderson must establish a specific causal connection between the specific toxic organic solvent to which she was exposed and the specific polymicrogyria birth defect is generally accepted in the scientific community." Id. at 611 (emphasis added).

In rejecting this exacting level of scientific certainty (which was an issue of first impression for the Supreme Court, id. at 605), the Supreme Court not surprisingly overruled the Court of Appeals in Grant v. Boccia, 133 Wn. App. 176, 137 P.3d 20 (2006) and Ruff v. Dep't of Labor & Indus., 107 Wn. App. 289, 28 P.3d 1 (2001) to the extent the opinions were inconsistent.

Both Grant and Ruff applied a stringent Frye analysis, which Akzo relied upon in advancing its theory that the Frye test required a high level of exacting science. As such, the Anderson Court slightly relaxed the Frye test, as applied earlier by the Court of Appeals in Grant and Ruff. In the case at bar, both parties relied on Grant and Ruff in the trial court briefing, however, AHC relied on many other cases (such as Frye v. United States, State v. Cauthron, and State v. Copeland) which the Anderson Court also discussed and applied in reaching its holdings.

Neither the holdings in Anderson, nor the reversals of Grant and Ruff alter the outcome of the trial court's ruling in Mr. Guscott's case. Under *de novo* review, the trial court properly applied the facts to the Frye test, ruling:

- The major issue in this case is whether falling out of a wheelchair and landing on one's buttocks can cause an AAA to leak or rupture.
- Each of Mr. Guscott's three experts hold this opinion, which is contested by Advanced's experts, yet there is no scientific basis in the record to support that the principle is generally accepted in the scientific community.
- Mr. Guscott's three experts conceded that they did not know of any scientific literature supporting their theories. Guscott has not found and provided any such literature, nor has he provided any other scientific evidence to support his theory, despite ample opportunity to do so.
- This testimony is stricken under *Frye*.

(CP 342-43) Accordingly, under Anderson, and as a matter of law, Mr. Guscott's expert opinions were properly excluded.

E. The Standard of Review Is “Abuse of Discretion” of the Trial Court’s Order Denying Reconsideration.

Motions for Reconsideration are addressed to the sound discretion of the trial court, and on a subsequent appeal, a denial is reviewed for abuse of discretion only. Wilcox v. Lexington Eye Inst., 130 Wn. App. 234, 122 P.3d 729 (2005) *rev. denied* 157 Wn.2d 1022, 142 P.3d 609 (2005); Go2Net, Inc. v. C I Host, Inc. 115 Wn. App. 73, 89, 60 P.3d 1245 (2003).

F. The Trial Court Properly Exercised its Discretion in Not Accepting Late Materials.

A Motion for Reconsideration must be expressly premised on one of nine bases set forth in CR 59. CR 59(a)(4) addresses submission of newly discovered evidence. For the moving party to offer and rely on newly discovered evidence, CR 59(a)(4) mandates that the evidence must be that “which [Guscott] could not with reasonable diligence have discovered and produced at the [original motion].”

Here, Guscott had more than six (6) weeks in which to submit any evidence in opposition to AHC's Frye motion. In fact, the Court noted in its letter opinion and order that Guscott had “*not found and provided any such*

literature, nor ha[d] he provided any other scientific evidence to support his theory, despite ample opportunity to do so.” (CP 342) Rather, for the first time, in his Declaration in Support of Motion for Reconsideration, Mr. Guscott submitted over 250 pages of additional documentation, including a handful of old medical articles. (CP 433-652; CP 756-63)

There are five requirements that must be satisfied by the moving party to allow submission of newly discovered evidence under CR 59(a)(4):

- 1) It must be truly newly discovered evidence – not simply evidence that was available but not previously presented;
- 2) All due diligence must have been used to discover and present the evidence; and that despite such diligence, the newly discovered evidence was not discovered until too late;
- 3) The evidence is material to the merits of the case and would be admissible and more than merely cumulative or impeaching evidence;
- 4) The evidence must be described in sufficient detail; and
- 5) Be of such strength that there is a probability it might change the result.

CR 59(a)(4).

Mr. Guscott’s Motion for Reconsideration failed to address, reference or discuss any of these requirements. The trial court stated that “He does not argue that this [additional] evidence was previously unavailable, but states instead that he did not believe that the court would rule in the way that it did

and therefore did not think he had to present this evidence in earlier proceedings.” (CP 784) Here, Mr. Guscott again overlooks the requirements of CR 59 and CR 59(a)(4). His opening brief with this Court is void of any reference to CR 59.

Mr. Guscott ignored CR 59(a)(4) and relied instead solely on State v. Copeland, 130 Wn.2d 244, 255-56, 922 P.2d 1304 (1996) for the proposition that the reviewing court, even after several levels of appeal, “will undertake a searching review which may extend beyond the record and involve consideration of scientific literature as well as secondary legal authority.” He argued that the trial court was the “reviewing” court and, therefore, it should consider his newly submitted scientific articles.

AHC argued in trial court that Mr. Guscott presents an erroneous interpretation of Copeland. First, the appellate court is the “reviewing” court, not the trial court. Copeland anticipates several levels of appeal—not several levels of reconsideration in the trial court, as Mr. Guscott suggests.

Second, the Copeland Court recognizes that science is constantly evolving. Accordingly, evidence submitted to the trial court to demonstrate “general acceptance” in the scientific community, may in fact, be disproven by new evidence that is established in the scientific community during the

course of an appeal. For example, Copeland cites Cauthron's position that it relied upon a scientific *report issued after oral argument*. Copeland, 130 Wn.2d at 256.

Copeland also acknowledges that “new technology, evolving at a pace where general acceptance changes *from time of trial to time of appellate review* is at [the] core of what *Frye* is designed to scrutinize.” Copeland, 130 Wn.2d at 257 (citing State v. Bible, 175 Ariz. 549, 858 P.2d 1152, 1189 n.33 (1993) (emphasis added) (noting that we consider scientific literature published, as well as cases decided, *after trial*).

In contrast, Mr. Guscott submitted scientific evidence to (1) the trial court for the first time in his motion for reconsideration, (2) that included an article published in 2007 (CP 494-511); in 1983 (CP 512-17); an unidentified and undated document (CP 638-44); one-page abstracts from 2007 (CP 646); 2002 (CP 647-52); and 2006 (CP 756-763). All of these articles—published well before 2010—were available to Mr. Guscott when AHC challenged Mr. Guscott's novel theories in 2010. These new submissions failed to comply with the requirements of CR 59(a)(4) as well as Copeland.

The trial court, after hearing oral argument, exercised its discretion and fully denied reconsideration and declined to review newly supplied

materials. The trial court ruled as follows:

- (a) Although the Court did not hold what Guscott terms as a Frye hearing, all parties were aware of what was at issue at the Motion in Limine hearing. Guscott was on notice that Advanced Health Care questioned the experts put forth by Guscott. The parties knew what was at issue, and the burdens were well known in terms of what needed to be brought forth in light of the challenge.
- (b) At the time of being so challenged, Guscott had a threshold burden to present evidence in light of the challenge to his experts. Guscott was provided a full opportunity at that time, and he did not meet that threshold burden.
- (c) The new materials that have been brought forth in Guscott's Motion for Reconsideration were available to Guscott previously at the time the Court considered the initial Motion *in Limine*.
- (d) It also appears from Guscott's most recent submissions that since the initial Motion *in Limine*, opinions of Guscott's experts have changed—both in substance and basis. New theories are not admissible on motions for reconsideration.

Finally, the trial court agreed with AHC's interpretation that State v. Copeland (1) allows an appellate court, not a trial court on reconsideration, to consider new materials outside the record; and (2) acknowledges that "new technology, evolving at a pace where general acceptance changes *from time of trial to time of appellate review* is at [the] core of what *Frye* is designed to scrutinize." Copeland, 130 Wn.2d at 257. Accordingly, the appellate court reviews only evidence that was unavailable at the time the trial, such as

heretofore unpublished papers, test results, etc. (CP 936-37)

AHC respectfully requests that the Court of Appeals affirm the trial court's denial of reconsideration. After six weeks of intense briefing on the application of Frye and Mr. Guscott's failure to submit scientific evidence in support of his expert's novel theories, the trial court certainly did not abuse its discretion in denying reconsideration of materials submitted in derogation of CR 59(a)(4).

G. Mr. Guscott Was Fully "On Notice" That AHC Was Challenging His Experts Under Frye.

In his Opening Brief, Mr. Guscott concedes that "[t]wo months before trial, AHC served its motion *in limine*" wherein AHC "urged application of the *Frye* test to bar the experts' opinions—that a hard fall from a wheelchair was a cause of Mr. Guscott's leaking AAA." (Appellant's Opening Brief at 20) He was clearly cognizant that AHC was challenging his experts' opinions and scrutinizing those opinions under *Frye*.

It is extremely disingenuous for Mr. Guscott to now contend that he had no idea that AHC was applying Frye to bar his experts' novel theories. (Appellant's Opening Brief at 41) He contends that he is entitled to a "Frye Hearing." (Appellant's Opening Brief at 1, 17, 19, 27)

First, Mr. Guscott never requested an evidentiary hearing despite

ample opportunity. To the extent that he believes he was entitled to what he calls a “Frye Hearing,” he should have simply requested one, though he certainly participated in AHC’s Motion *in Limine* hearing.

Second, AHC’s motion, titled “Motion *in Limine* Re: Exclusion of Counter-Claimant’s Experts,” expressly cites, discusses, and applies the “Frye” case at least 11 times with respect to excluding Mr. Guscott’s experts. (CP 960-78) AHC clearly stated the relief it sought: “The causation opinions of these three experts should be excluded.” (CP 977) In its reply brief, AHC stated “It is true that AHC is asking the Court to strike all of Guscott’s [expert] witnesses.” (CP 284) Likewise, AHC argued that “Guscott’s experts should not be permitted to offer their varying unsupported causation opinions.” (CP 285)

Mr. Guscott filed responsive briefing, including an unsolicited supplemental brief after oral argument. On December 17, 2010, after reviewing and considering 22 documents submitted by both parties and hearing oral argument, Judge Carol Murphy ruled that Mr. Guscott’s experts are qualified under ER 702, but that the record lacks support for their scientific opinions under Frye. (CP 341) Mr. Guscott’s contention that he did not get a Frye hearing is meritless.

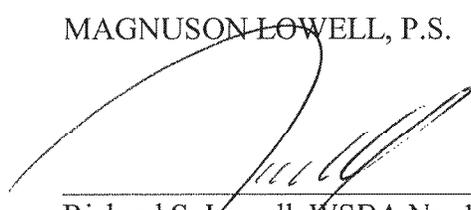
VI. CONCLUSION

Respondent Advanced Health Care, Inc. respectfully requests that the Court affirm the trial court ruling to exclude Mr. Guscott's experts because their novel theories failed to meet the Frye test. Likewise, the trial court's ruling to deny Mr. Guscott's Motion for Reconsideration should be affirmed because the trial court did not abuse its discretion.

Dated this 3rd day of February, 2012.

Respectfully submitted,

MAGNUSON LOWELL, P.S.



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CERTIFICATE OF SERVICE

THIS IS TO CERTIFY that on the 3rd day of February, 2012, I caused to be served a true and correct copy of the foregoing via U.S. mail, postage prepaid and addressed to the following:

Carl Lopez
Lopez & Fantel
1510 14th Avenue
Seattle, WA 98122

Debra A. Thomas, P.C.
173 Hillcrest Avenue
Glen Ellyn, IL 60137

A handwritten signature in cursive script, appearing to read "Linda A. Cullen", written in black ink.

VII. APPENDIX

Excerpt from Deposition of Dr. Kaj Henry Johansen
@ CP 144 @ 6:4 – 11:16

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON
IN AND FOR THE COUNTY OF THURSTON

ADVANCED HEALTH CARE, INC., a)	
Washington corporation,)	
)	
Plaintiff,)	
)	
vs.)	No. 07-2-00599-1
)	
ARTHUR T. GUSCOTT,)	
)	
Defendant.)	

Deposition Upon Oral Examination Of
KAJ HENRY JOHANSEN, M.D.

4:15 p.m.
May 11, 2010
1600 East Jefferson
Seattle, Washington

REPORTED BY: Yvonne A. Gillette, CCR No. 2129.

1 Q So you are still working full time?
 2 A Absolutely.
 3 Q And what is your current position?
 4 A I'm a staff vascular surgeon at the
 5 Polyclinic, which is a large multidisciplinary medical
 6 clinic here in downtown Seattle. I'm the medical
 7 director of vascular surgical services for the Swedish
 8 Heart and Vascular Institute and a clinical professor
 9 of surgery at the University of Washington School of
 10 Medicine.
 11 Q With respect to the case that we are here
 12 for, what have you reviewed?
 13 A So I have reviewed the incident records of
 14 Arthur Guscott, which is to say those of the period of
 15 time around the end of 2006 when he had this ruptured
 16 aneurysm and its repair. And I have been provided
 17 selected records of, I think, of some elements of his
 18 health care at some point prior to that.
 19 I had -- let's see. You asked me the
 20 records. I think that's the extent of the records
 21 that I have reviewed regarding Guscott himself.
 22 Q Okay. Now, as far as the-- do you recall
 23 which of the health records you were provided?
 24 A No.
 25 Q Okay. Do you know if you were given any--

1 obviously, he had a AAA. So I presume you were given
 2 some records related to his AAA?
 3 A Yes.
 4 Q Have you been able to form opinions with
 5 respect to the AAA that Mr. Guscott had?
 6 A I think the issue in this case, I think the
 7 case starts and ends with the issue of whether the
 8 fall, slide, whatever it is, out of the wheelchair on
 9 December 25, 2006 was a proximate cause of the aortic
 10 aneurysm rupture that was identified three days later
 11 on December 28, 2006. It's my impression that the
 12 case revolves around that. And there are not any
 13 other, at least I'm not aware of any outstanding
 14 allegations.
 15 Q That's fair.
 16 A In that context, I do have -- I have formed
 17 an opinion.
 18 Q Please.
 19 A And that is that the aneurysm ruptured as a
 20 consequence of its size, and that the fall or slide
 21 out of the wheelchair was not relevant to-- was not a
 22 proximate cause of that rupture.
 23 Q Is there-- on what do you base that?
 24 A That's based on the following several
 25 issues. First, I have a long standing involvement

1 with aortic aneurysm rupture. And I'm confident that
 2 you will have seen publications of mine. I think it's
 3 probably superfluous that I have given you my CV, but
 4 I have been involved with ruptured aneurysms since the
 5 first day of my practice. And I have arguably the
 6 largest experience in the U.S. in ruptured aneurysms
 7 because of the fifteen years I spent as chief of
 8 vascular surgery at Harborview. I don't recall
 9 whether you are from around here, but Harborview is
 10 the big receiving hospital for this whole four state
 11 area. So I have operated on and cared for hundreds
 12 and hundreds of people with ruptured abdominal aortic
 13 aneurysms. And in no case in my personal experience
 14 have I ever had even the inkling that a preceding
 15 trauma led to or was linked to rupture of the
 16 aneurysm. That's the first point.
 17 The second point is the physics of aneurysm
 18 rupture and the specific vectors of force in this
 19 particular case which were visited upon this guy's
 20 very large aortic abdominal aneurysm. So far as any
 21 of us understands, the force in this case was in what
 22 I would term an axial direction, A-X-I-A-L, which is
 23 to say along the course of the aneurysm, which if you
 24 were going to try to protect an aneurysm from
 25 rupturing is the direction in which you would do it.

1 It's straight along the course of the aorta. That
 2 would be my second argument.
 3 The third is an essentially negative
 4 literature search that I have carried out going back
 5 into the 1970s for any sort of suggestion that trauma
 6 has been associated-- a preceding trauma in some
 7 fashion has been associated with aortic aneurysm
 8 rupture. And I can tell you that I have found a paper
 9 related to two patients reported from the University
 10 of Louisville in Kentucky I think in 1997 in the
 11 local -- the state medical journal in which they talk
 12 about two individuals with significant vehicular motor
 13 vehicle accident trauma which had aneurysms that
 14 acutely ruptured. These were individuals with
 15 substantial indications of trauma, so-called seatbelt
 16 sign and so forth, and are not relevant in regard to
 17 this case.
 18 More importantly in this entire search of
 19 the literature, of which I am extremely familiar, so
 20 far as I can tell, notwithstanding the fervent
 21 assertions of experts on Mr. Guscott's side of the
 22 case that everybody knows this is true, this is the
 23 only thing I have been able to find in the literature
 24 in this regard relating trauma to subacute rupture of
 25 an abdominal aortic aneurysm.

1 And that leads me to my further point, which
 2 is what is being invoked here is not the very high
 3 likelihood that any vascular surgeon would agree with,
 4 that a 9.4 centimeter abdominal aortic aneurysm is
 5 about to rupture at any point. It is not that. But
 6 rather that what Guscott argues in this case is that
 7 we are obliged to presume that the aneurysm
 8 asymptotically leaked, because the patient had no
 9 real symptoms consistent with an aneurysm leak, much
 10 less rupture, on Christmas day 2006. And it silently
 11 continued to leak until three days later when it was
 12 identified.

13 If this were the case, we should at least
 14 upon occasion see cases of individuals with aneurysms
 15 which, either asymptomatic or being imaged for some
 16 other reason, are found to have extravascular blood,
 17 which is to say, that blood has exited the aneurysm in
 18 some fashion at some point in the past. Because as
 19 Dr. Gore has said, it leaves its tracks there. And
 20 notwithstanding his assertion that he had seen this in
 21 a number of cases, although I think by my reading of
 22 it, it seemed to me, he could only actually come up
 23 with a single case, it's just not seen. I have not
 24 seen that or even heard of that. And none of the
 25 radiologists with whom I have spoken has ever been--

1 has ever seen this issue either, that is, of an
 2 aneurysm which has leaked then even for a few days or
 3 weeks or months and has stopped. That certainly has
 4 been reported. but it's vanishingly rare.

5 And Guscott necessarily argues here that an
 6 exceedingly rare situation with a very large aneurysm,
 7 which is to say, it leaks a little bit and then stops,
 8 is actually what happened here with quite minimal
 9 trauma, as opposed to what any vascular surgeon would
 10 say is the certainty, that in fact this was just an
 11 aneurysm that was ready to leak on December 28th.

12 The final point that I would make arises a
 13 bit out of also some of my published research, which
 14 is sort of biophysical research about aneurysms. I
 15 think this is my fifth point. Although, who's
 16 counting here.

17 Q It is your fifth.

18 A It is that aneurysms are not particularly
 19 fragile. A 9.4-centimeter aneurysm, its wall is
 20 relatively thick. If you hit it, it's not
 21 significantly less thick than that of an aneurysm half
 22 its size. Aneurysms rupture on the basis-- and I beg
 23 you to be patient with this. But it's a sort of a--
 24 the scientific explanation is that they rupture on the
 25 basis of wall tension, which is a product -- it's a

1 function of the pressure and the size. The wall
 2 tension, Tau, T-A-U, the Greek letter Tau is a
 3 function of the product and the size of the aneurysm.
 4 It's not that the very large aneurysm here is
 5 intrinsically fragile. It's the wall tension rises
 6 logarithmically as it goes up like this.

7 While Guscott's experts have talked
 8 voluminously and repeatedly about how trauma causes
 9 aneurysms to rupture, there is neither in the medical
 10 literature, nor experience of people who actually take
 11 care of them, nor biologically, which is to say, in
 12 animal systems, nor in terms of the physics of it, is
 13 there any sort of sense that trauma of the sort that
 14 Guscott suffered caused-- would cause an aortic
 15 aneurysm, however large, to rupture. Those are my
 16 opinions.

17 Q Do you think trauma can never cause an
 18 aneurysm to rupture?

19 A Certainly a penetrating trauma, gunshot
 20 wound, stab wound, something like that. And there is
 21 no doubt that severe deceleration, which is to say,
 22 where your car hits the bridge at 70 miles an hour,
 23 seatbelt trauma, could rupture the abdominal aorta.
 24 It has been reported, so-called seatbelt aorta, where
 25 the aorta can be severed. This is usually seen in

1 people who are dead at the scene. But if the seatbelt
 2 can bluntly sever the intrarenal aorta, it certainly
 3 can occur in somebody with a large aneurysm.

4 But I repeat again that the aneurysm is not
 5 thinned out or anything like this. When it ruptured,
 6 it is because of this wall tension thing, tension
 7 along the course of the wall not normal to it.

8 Q Do you have an opinion as to what caused
 9 Mr. Guscott's aneurysm to rupture?

10 A Yes. There's only one cause. And I have
 11 alluded to it. And that is that when wall tension is
 12 exceeded by-- exceeds some point where the tension
 13 exceeds the tissue integrity, then it opens up, and
 14 then it bleeds a bunch.

15 And I guess I would like to refine one of my
 16 further answers or expand upon it a bit. It is the
 17 bit in which we were talking about how Guscott argues
 18 that his aneurysm leaked and it sort of continued to
 19 leak until it presented three days later. That's not
 20 the way-- the behavior of aortic aneurysms is that
 21 they essentially always-- blood issues forth from the
 22 aneurysm. And if it issues forth freely into the
 23 peritoneal cavity, then the patient dies in minutes.

24 If it issues in the retroperitoneum, then it
 25 frequently will tapenade itself. Tapenade means sort

MAGNUSON LOWELL, P.S.

February 03, 2012 - 3:33 PM

Transmittal Letter

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